US infusions
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RECLAST/ZOLEDRONIC ACID INJECTION ORDERS

PATIENT INFORMATION:

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:** _____

DIAGNOSIS AND ICD-10 CODE:

☐ M80.0 – Age-related osteoporosis with current fracture

☐ M81.8 – Osteoporosis w/o current fracture

☐ M80.8 – Other osteoporosis with current fracture

☐ M81.0 – Age-related osteoporosis w/o current pathological fracture

☐ Other diagnoses: _____

PRESCRIPTION:

☐ Zoledronic Acid 5mg IV infusion over 15 minutes

Premedication: ☐ Tylenol 1000mg **OR** ☐ Ibuprofen 400mg

THERAPIES TRIED AND FAILED:

Bisphosphonates for osteoporosis with start and end dates and reasons for discontinuation (intolerance, contraindications, fractures, impaired kidney function):

_____

REQUIRED ASSOCIATED DOCUMENTATION:

☐ Patient demographics ☐ Front/back of all insurance cards ☐ Current medication list

☐ Include clinical notes supporting one or more of the above diagnoses.

☐ Include Dexa scan results to support osteoporosis diagnosis: ☐ T-score of < -3.0 overall, ☐ T-score of ≤ - 2.5 in the lumbar spine, femoral neck, total proximal femur, or 1/3 radius, ☐ T-score between -1.0 and -2.5 and a fragility fracture of the proximal humerus, pelvis, or distal forearm.

☐ Include lab test results: ☐ CMP reflecting normal calcium levels and kidney function.

☐ Include all supporting diagnostic radiographic reports and images of fractures attributed to one or more of the above diagnoses.

PROVIDER INFORMATION:

By signing this form, you authorize US Infusions and its staff to handle prior authorizations, coordinate with insurance providers, and determine the patient's preferred site of care.

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

FAX COMPLETED FORM TO US INFUSIONS AT 469-200-2606